

Full Length Research Paper

Integrated MicromediClaim-SHG-Bank-Linkage model in consolidating women empowerment in India like an emerging nation

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It is a known fact that there are three agents of underdevelopment, that is, poverty, disease and ignorance in the world. Micromedi claim in India presently is too small to create a great impact in poverty alleviation, but if provided with new technologies for skills and opportunities for the development of the poor, it holds to change the socio-economic face of the India's poor. The self-help group (SHG) model with micromedi claim through SHG group leading to groups without collateral has become an established part of rural development with financial inclusion. SHG-based micromediclaim which is run and supported by NGOs, have become a significant alternative to traditional medical insurance in terms of reaching the poor without increase in operating and monitoring costs. The government and financial institution have accepted this and have highlighted the SHG model and taken initiatives to work along with NGOs. Millions of SHGs have been linked to banks over the years, but still most of the states are not doing well to establish the development, link up the social responsible process of the poor and nurture the various schemes of the government. This paper also discusses why rural poor easily get the mediclaim from 'regional rural bank' by using this Micromediclaim-SHG-bank linkage model.

Key words: India, micromediclaim, financial inclusiveness.

INTRODUCTION

The Indian state put stress on providing financial services to the poor and underprivileged since independence. The commercial banks were nationalized in 1969 and were directed to lend 40% of their loanable funds, at a concessional rate, to the priority sector. The priority sector included agriculture and other rural activities and the weaker strata of society in general. The aim was to provide resources to help the poor to attain self sufficiency with well health and nutritious facility for realizing the food security Bill, 2011 in our nation (Seibel and Dave 2002). They had neither resources nor employment opportunities to be financially independent, let alone meet the minimal consumption needs for better health condition through this micro mediclaim.

Micromediclaim refers to small scale medical services for both the poor and the penniless women that are

provided to people, such as the neglected groups who are not getting the appropriate medical facility for their better health and stealth, which affect their day to day occupational life and the working condition contrive them to severe health problem. It is the task of micromediclaim institution to provide good hygienic medical help to individuals and local groups in developing countries in both rural and urban areas.

The growth of Microfinance sector in India is a new concept to the Indian health market. There exist different approaches and models of microfinance; the most predominant in operation among them is the Self Help Group (SHG) model. The SHG interventions in the country have reached out to more than 17 million households becoming the largest micro mediclaim endeavours in the world in terms of outreach. The Indian

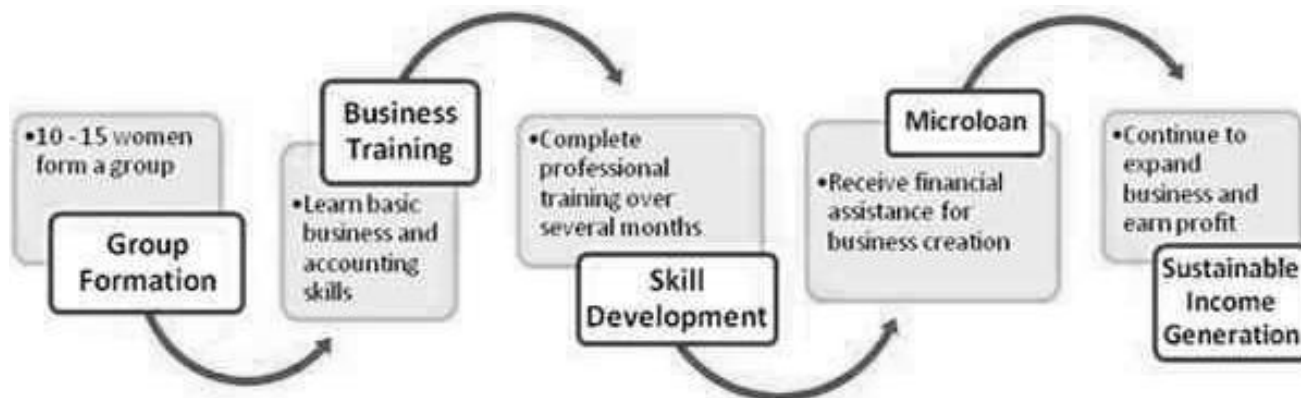


Figure 1. Model showing issues on sustaining SHGs.

micro medical experience is unique in its diversity and has involved the stakeholders such as NGOs, micro medical intermediaries, donor agencies, NABARD, SIDBI, commercial banks, insurance providers, Self Help Groups (SHGs) and their federations, research and academic institutions and the government. The apex financing institutions and commercial banks have played a critical role in the tremendous growth of micro medical in India through the SHG-Bank linkage programme (Bansal 2003). The state governments have shown keen interest in micro medical as part of their development agenda and they support large scale micro medical programmes. Despite the remarkable growth and feats of the SHG movement in the country, sustainability of the SHGs continues to be a major concern. It has now been well established that access to a range of micro medical services through SHG can bring about significant changes in the lives of the poor. SHGs proved to be a good tool for organizing the unorganized and for building social capital. The impact of SHGs has been well demonstrated on the aspects such as arresting leakages in household cash flows, increasing income, enhancing asset status, building self-esteem and confidence of women, improving health qualities, etc. However, it should be understood that these are mere beginnings and there is a lot to be done and accomplished. Considering the complexity of poverty issues, there is an enormous need to retain and take these achievements forward through generations for comprehensive poverty reduction. But the SHGs in India remain to be the 'populist programmes' of state governments supported by larger bilateral donors, and when there is a setback in these factors the very existence of these groups becomes an issue. There are very few examples in the country on deepening micro medical through federating these SHGs, mainly attributed to diversity of perspectives and institutional capacity among stakeholders on the issue. By many, sustainability is still perceived as mere financial self sufficiency ignoring other vital factors such as governance building, transformation of roles between the

promoting organisation and people, creating institutional systems and processes, resource mobilization and management, building alliances with other partners, etc. On the other hand, there are quality concerns leading to increase in number of dysfunctional groups and challenges like continuity in linkages with banks, and multiple lending. There is also a serious need for capacity building of SHG promoting organizations to impart 'know-how' on federating SHGs and establish mechanisms for achieving sustainability with betterment of their standard of living with good health position. There is a need for assimilating the wisdom of successful experiences and issues on sustaining SHGs and charting out a way forward for policy advancement (Figure 1).

The medical facility scheme, Integrated Rural Development Programme (IRDP), was launched in 1980, but these supply side programs (ignoring the demand side of the economy) aided by corruption and leakages, achieved little. Further, the share of the formal financial sector in total rural medical facility was 56.6%, compared to informal finance at 39.6% and unspecified sources at 3.8% (RBI, 1992). Not only had formal medical facility flow been less but also uneven. The collateral and paper work based system shied away from the poor. The vacuum continued to be filled by the village money lender who charged interest rates of 2 to 30% per month. 70% of land less/marginal farmers did not have a bank account and 87% had no access to medical facility from a formal source. It was in this cheerless background that the Micro medical Revolution occurred worldwide. In India, it began in the 1980s with the formation of pocket size formal Self Help Groups (SHG) engaging in micro activities financed by Micro finance. But India's first Micro finance Institution, ShriMahila SEWA Sahkari Bank, was set up as an urban co-operative bank by the Self Employed Women Association (SEWA) soon after the group (founded by Ms. Ela Bhatt) was formed in 1974.

The first official effort materialized under the direction of NABARD (National Bank for Agriculture and Rural Development). The Regional Rural Bank also provided the special loan for this micro medical facility in the rural

areas which led the rural area to be financially included. This institution also got the better chance for mediclaim of the SHG group and took the better part in this medical insurance.

RESEARCH METHODOLOGY

This study was based on an innovative idea which encompasses different forms of methods and suggestional forms of method to prove that this study's method is the utmost method for betterment of the society. As it is the integrated study on both microfinance and micromediclaim, it indicates that the micromediclaim is another form of integrating microfinance with taking the micro mediclaim in the market. There are different companies providing the mediclaim and the insurance, but their policies are not so appropriate in the market. So how will it touch everybody in the society, their life pattern as well as the life saving factor of the society, in addition to India like an emerging nation. So this research is based on the availability of data obtained from mediclaim in touching the heart of the people in every way and at an affordable price. In addition, this paper observed the different problems faced by the microfinance companies and the documentation process by which the people avail their mediclaim in our nation.

MFIs, self help groups, income generation and women empowerment

Microfinance programs in developing countries were enormously successful in providing medical facility without any collateral to the poor women who are largely bypassed by the conventional banks. Their success attracted the attention of both academic economists and policy practitioners around the world, and the flagship microfinance program (Grameen Bankin Bangladesh) and its founder (Muhammad Yunus) have been awarded Nobel peace prize in 2006. There is now a voluminous literature analyzing different aspects of the microfinance revolution that swept across the developing world in the last thirty years. The MFIs stress on asset creation by the SHGs and extend loans for production and provides training for the same. If any member needs medical facility beyond the stipulated limits, they are allowed to draw from group funds and the amount is settled in the periodic (monthly) group meetings. SHGs consisting of poor members with identical socioeconomic backgrounds are usually more sensitive to the medical facility needs of the poor. Under the micro mediclaim programme, loans are extended to the 'Self Help Groups (SHG) who pool apart of their income into a common fund from which they can borrow to wards' bank for medical insurance system. The members of the group decide on the minimum amount of deposit which ranges from Rs. 20 to Rs. 100 per month depending upon the size of the group. The group funds are deposited with a Micro

Finance Institution (MFI) against which they usually lend (the deposits are usually placed with a bank by the MFI) at a premium deposit ratio of 10,000:1 but the ratio improves with account performance record. The group funds is the way 'micro savings' are enforced, though it may seem like a collateral. The premium deposit sizes are usually Rs. 200 to Rs. 15000. Maintaining group reputation leads to the application of tremendous peer pressure.

In India and other Asian countries, the majority of SHGs consist of women because, in these countries, Self Employment through Micromediclaim was perceived as a powerful tool for emancipation of women. It has been observed that gender equality is a necessary condition for economic development. The World Bank reports that societies that discriminate on the basis of gender are in greater poverty, have slower economic growth, weaker governance, and lower living standards.

Loans obtained from MFIs are utilized in agriculture and small businesses. Independent incomes and modest savings have made women self-confident and helped them to fight poverty and exploitation. "Previously we had to shy away before our husbands to ask for one rupee". They do not have to wear tattered sarees any more and, today, they have the confidence to come and talk to you without seeking permission from our husbands.

Empowerment through micromediclaim

Here are some of the empowerment functions performed through micromediclaim:

- Capacity to save and access mediclaim insurance.
- Opportunity must be provided to undertake an economic activity.
- Opportunity to visit nearby urban areas.
- Knowledge of local issues, MFI procedures to provide loan, banking transactions.
- Skills for claim settlement.
- Decision making within the household.
- Group support to individual clients-action on social issues.
- Role in community development activities with mediclaim should be provided at the spot local PHC.

Financing the SHGs

In India, the adaptation of the new microfinance approach by rural financial institutions assumed the form of the "Self-Help Group-Bank Linkage Program." After an initial pilot study, the RBI setup a working group on non-governmental organizations (NGOs) and SHGs. The working group made recommendations for internalization of the SHG concept as a potential intervention tool in the area of banking with the poor. The RBI was quick to accept their commendations and advised the banks to consider mainstreaming lending to SHGs as part of their

rural medical facility operations.

The financial needs of the SHGs are catered for by various financial institutions: the Commercial Banks, Co-operative Banks, Co-operative Medical facility Societies and Regional Rural Banks (RRB) (Bhatt and Thorat 2001). They finance the SHGs directly or route their funds through a micro finance Institution set up by an NGO (NGOMFI) or Non-Banking Financial Companies (NBFC).

Specially in Odisha, "Trupti" is operating in all district by Panchayati raj Department of Odisha Government to every village for having the best linkage between the SHG group to Bank linkage, commencing meeting, forming the group, financial assistance through the bank and giving the best facility for the marginal group. So, it is creating a good environment not in Odisha but in the different states like Tamilnadu, Andhra Pradesh, and Gujarat. It is adding the Rural Livelihood Mission for better development of the rural people. So it creates a better atmosphere for national poverty eradication facility in our nation.

The NGO-MFIs (the major source of MFIs in India) disburse loans from the line of loan facility which is provided to them by a Financial Institution. The advantages of intermediation of funds through NGOs are manifold. It leads to reduction in time of identification of medical facility worthy people, documentation and recovery. The falling transaction cost is not less than 40%.

In line with developing saving and medical facilities, the NGOs engage in:

- (1) Providing basic education.
- (2) Providing education of health and hygiene.
- (3) Providing education and encourage family planning.
- (4) Awareness about environment protection and biodiversity.
- (5) Fostering an environment of gender equality.
- (6) Claim facility and their uses in day to day life.

In India, three types of SHG models have emerged:

1. Bank-SHG-Members: The bank itself acts as a self-help group medical promoting institution (SHMPI).
2. Bank-Facilitating Agency-SHG-Members: Facilitating agencies like NGOs, government agencies, or other community-based organizations form groups.
3. MFI-Bank-Medical-NGO-SHG-Members: NGOs act both as facilitators and micro mediclaim intermediaries. First they promote groups, nurture them, and train them, and then they approach banks for bulk loans for lending to the SHGs.

Sustainability of micromediclaim

Based on the success of new MFIs, India has ventured into official collaboration between NGOs, financial

institutions, and the government of India. Collaboration between these organizations has been an outcome of greater emphasis on a community approach to medical facility through participatory method. Moreover, the need to be cost effective and sustainable while reaching the poorest is also an important factor in the collaboration of formal structures and NGOs.

In spite of the optimism generated by the expansion of SHG medical facility and the high recovery rate (According to NABARD 2003-2004 report on SHG bank linkage, it was more than 95%), there is a gap between actual per capita medical facility provided to the poor and the demand.

The distribution of Microfinance in India was highly skewed, with 65% of the SHGs being in Southern India and these SHGs were enjoying 75% of the medical facility disbursed.

Though there is limited data on the accessibility of the poor in India to Micro mediclaim programmes, available evidence suggests that 80% of the poor do not have any savings and 91% are without any formal medical facility. The effective rate interest charged by the MF institutions is in the range of 14 to 36% p.a. In a country of one billion, where 25% of the population (As on 1st January, 2004 as per the CIA World Factbook) are below the national poverty line, and even among those above the poverty line, very few can afford to pay these kinds of interest rates. They may be able to only at a great cost and up to a limited time. One reason why high interest rates prevail is because timely availability of medical facility is more important than cost of medical facility *per se*. So interest rate should slump or be special for this purpose. Government data show that scheduled tribes and castes exhibit much higher poverty rates than the average population, with women and children suffering the highest incidence of poverty as well as poorer health and education outcomes.

CHALLENGES

1. In India as regards Micromediclaim programmes, available evidence suggests that 80% of the poor do not have any savings and 91% are without any formal medical facility, while 80% of the people do not have access to the medical facilities and depend upon the local "baidya" or are still herbal dependent on the alternative treatment which is based on superstition in tribal areas and many remote areas in Odisha and Madhya Pradesh (Kropp and Suran 2002). Providing microfinance facility at their door step with better medical insurance facility and a movable medical facility is the main motto which this study stressed on Tribal bank facility which make up for better facility for different people at their door step and which provide different financial as well agricultural facilities to the remote areas for better allocation of their local natural resources in their areas.

2. Illiteracy and insufficient organizational experience of most SHG group members constrain the governance

capacity in SHG group. This constraint, inherent to an organization of poor women, affects the ability of the group members to effectively perform over sight functions. Few group members were able to identify oversight of staff as one of their roles. Insufficient understanding of auditing expressed by the group members also reflected this weakness; group members perceived auditing more as a means to check for accounting errors rather than as a check on management.

3. One of the strengths of SHG group is its capacity to have staff to perform specialized functions. Furthermore, most or all the staff are locally recruited. The long-term strategy is to help the SHG group recruit professionals directly.

4. Good systems provide efficient means to carry out routine functions of a group. Such systems should be cost effective and easy to use, while ensuring sufficient controls and efficiency. The groups need to improve their systems and processes. Risk management, repayment monitoring, and financial management are some of the systems which need increased attention.

5. Accountability in a member-owned organization depends primarily on ability of the members to hold the organization accountable. One of the major factors influencing this ability is the awareness of SHG members of their rights and duties as members as well as their capacity to use this awareness. As in the case of governance, the high level of illiteracy and lack of organizational experience of most members is a constraint for most SHG members in performing this role. Learning through experience contributes significantly to SHG members overcoming this constraint.

6. A good human development audit should touch to their life for auditing their cost of living, medical facility, hygienic life participation with development or slump and suggest to the government to take appropriate initiative for that purpose.

DISCUSSION

SHG-based micro-medicaid in India has made significant achievements by using this scheme for development of the region which needs a huge amount of the money for treatment. However, the financial sustainability of SHGs has not been clear because several of their costs are subsidized by organizations that had promoted them, and because few of their market costs are paid by SHGs on medicaid from banks. Similarly, their organizational sustainability is in doubt because of their small size, which limited the financial and human capital available to them, and thereby the services they could provide themselves.

NABARD plays a crucial role in the development of the SHG micro-medicaid program (Damodaran 2003). It takes the financial aid with financial assistance to micro finance Institutions on increasing the outreach of SHGs

and strengthening their linkage with the banking system for micro medicaid. However, given the exponential increase in the program in the recent years and similar trends observed in other micro medicaid programs around the world (including that of Grameen Bank) (World Bank 2003), the focus needs to shift to sustaining the benefits provided by SHGs. Despite the considerable achievements of the SHG-bank linkage program, sustainability of SHGs has not been clear (Harper 2002). The extent of sustainability and factors determining sustainability are not known. Knowledge on impact is also inadequate. The need to investigate these issues is long overdue. Factors that are likely to make the benefits of SHGs sustainable need to be identified. Fundamental questions such as whether SHGs need to be sustainable for the program benefits to be sustainable need to be tested. This shows that the SHGs need to be sustainable and it is suggested that SHG groups have the potential to contribute to this sustainability. This suggestion needs to be tested further. SHG federations studied for this paper provide several services to their member SHGs. These services help the SHGs gain economies of scale, obtain value-added services, reduce transaction cost, and enhance empowerment, thereby contributing to organizational sustainability of the SHGs. With the help of this scheme, primary focus should be given to the SHG involvement or participation, and then microfinance. Consequently, the micromedicaid will attain maximum success with better medical access.

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